

THE BREATH FACTORY

YOUR SNORING AND APNEA SOLUTIONS

Sleep Disorder Breathing Referral / Prescription Form

Patient Name: _____ Date of Birth: _____

Health Card Number / Medicard: _____ (C): _____

LOCATIONS: ☐ 1 Magazine Street, Saint John ☐ Bedford, Nova Scotia
☐ Dartmouth, Nova Scotia ☐ Elmsdale, Nova Scotia

☐ **Please do a level III sleep study (free testing available):**

Screen: STOPBANG > 3 positive responses

☐ *Check here if patient has atrial fibrillation / pacemaker*

Notes / comorbidities: _____

Diagnosis: _____ (for prescription)

CPAP Services

☐ Auto CPAP / BiPAP titration if indicated

☐ Existing CPAP /BiPAP patient
(Replacement device)

Settings if known: _____

☐ Bi-level Therapy or ASV on request

Settings: _____

Non CPAP Services

☐ eXciteOSA Therapy
(Genioglossus electrostimulation program for
snoring, mild OSA)

☐ Positional Therapy (SleepNoodle)
(For positional supine OSA)

☐ CBT-i for insomnia

☐ Aerobika Therapy - setting _____

Physician/NP: _____

Signature: _____

Phone #: _____

Fax #: _____

License #: _____

Date: _____

Fax your request:

Bedford
Fax: (902) 404-5474

Elmsdale
Fax: (902) 259-2805

Dartmouth
Fax: (902) 404-2357

Saint John
Fax: (506) 643-8874

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STOP BANG Screening Questionnaire

1) Snoring

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?

☐ Yes ☐ No

2) Tired

Do you often feel tired, fatigued, or sleepy during daytime hours?

☐ Yes ☐ No

3) Obstructive

Has anyone observed you stop breathing during your sleep?

☐ Yes ☐ No

4) High Blood Pressure

Do you have or are you being treated for high blood pressure?

☐ Yes ☐ No

5) Body Mass Index

BMI greater than 35 kg/m²?

☐ Yes ☐ No

6) Age

Age greater than 50 years old?

☐ Yes ☐ No

7) Neck circumference

Is the neck circumference (collar size) greater than 40 cm or 16 inches?

☐ Yes ☐ No

8) Gender

Male gender?

☐ Yes ☐ No

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Reference: Chung, F. et al. 2008

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